The Commonwealth of Massachusetts
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October 31, 2011

Centers for Medicare & Medicaid Services
Department of Health and Human Services
Attention: CMS-9974-P
Mail Stop C4-26-05
7500 Security Boulevard
Baltimore, MD 21244-1850

Re: Notice of Proposed Rule Making Regarding Patient Protection and Affordable Care Act; Exchange Functions in the Individual Market: Eligibility Determinations; Exchange Standards for Employers (Published in Federal Register Volume 131491, Number 10 on August 12, 2011)

To Whom It May Concern:

On behalf of the Commonwealth of Massachusetts we appreciate the opportunity to provide comments on the Notice of Proposed Rule Making regarding Exchange Functions in the Individual Market: Eligibility Determinations and Exchange Standards for Employers, published in the Federal Register on August 12, 2011.

The Commonwealth embraces national health reform and looks forward to the opportunity to further expand access to health insurance coverage to residents in our state through implementation of this law. Moreover, we are very proud to see that many components of the Patient Protection and Affordable Care Act (ACA) are based on elements of the Massachusetts model, including, for example, the individual mandate, standards defining minimum essential coverage and affordability, and the development of an Exchange to facilitate the purchase of health insurance.

Nonetheless, while many aspects of the ACA are broadly grounded in the elements of Massachusetts' health care reform initiative, we will have much work to do in the coming years to evaluate the consistency of our current policies and operations with new federal requirements. The Commonwealth is strongly committed to successfully adapting to federal health reform requirements to ensure Massachusetts residents have access to the full range of opportunities and benefits presented by the ACA.

Specific Comments

We appreciate the opportunity to provide comments to the proposed rule and offer ours in the following areas:

Definition of Federal Poverty Level (Section 155.300)
For eligibility for tax credits through the Exchange, the rule proposes that "Federal Poverty Level" be defined as the most recently published FPL amounts, as of the first day of the annual open enrollment period. In determining eligibility for Medicaid, states do not use the FPL amounts when they are published but rather when they become effective (usually in March). The Commonwealth has a concern about using different FPL effective dates (and potentially differing FPL amounts) for Exchange and for Medicaid eligibility as this will increase the complexity in the eligibility determination rules.

Notification of eligibility determination (155.310)
The Exchange regulations indicate that persons should be able to enroll in Exchange health plans shortly after the eligibility determination is made. At the same time, however, the regulations also state that this requirement does not override the open enrollment provisions. This could conceivably mean that there will be a large number of eligibility determinations sought in the period shortly before the open enrollment period. Given this potential enhanced volume immediately prior to an open enrollment period, and the possibility that some eligibility determinations may be complicated and require more time to be processed than might be available (depending on how far in advance of the open enrollment period the necessary materials are submitted), we would recommend flexibility in terms of enabling these individuals to enroll after the initial open enrollment period with coverage retroactively effective to the start of the open enrollment date. Please note, the state recognizes the importance of defined open enrollment periods to mitigate adverse selection, but would suggest this type of provision should be available to an applicant who has submitted their materials prior to the open enrollment, but for whom the eligibility process required more time than had been reasonably anticipated.

The Commonwealth also respectfully requests guidance on noticing requirements as soon as possible in order to incorporate notice planning into our overall Exchange planning efforts. The Commonwealth would appreciate clarification as to whether states are required to give a reason for Medicaid denial when a person is not eligible for Medicaid but is eligible for the tax credit.

Residency determination (Section 155.315)
Under the proposed regulations, the Exchange is required to determine and then verify residency for purposes of eligibility determinations. As in other areas of eligibility determination, such as eligibility for minimum essential coverage, the residency determination under the proposed regulation is made by the Exchange accepting the applicant's attestation without verification, unless the information provided by the applicant regarding residency is "not reasonably compatible with other information provided by the individual or the records of the Exchange," in which case the Exchange may examination information in data sources to verify. See proposed 45 CFR 155.315(c). The standard for residency is that the applicant "intend to reside" within the Exchange's service area.

The "intent to reside" standard is very subjective. There is no explicit requirement that the applicant actually reside in the Exchange service area at the time of application. Given these facts, it would be very difficult for the Exchange to determine whether the applicant's attestation is "not reasonably compatible" with other information, even if that other information indicates that the applicant lives out of state. Further, it would be difficult to find external data sources that could verify an intent to reside. Determination of state residency has significant implications for an Exchange. For instance, mandated benefits may differ from state to state, and state funds will be used to offset the cost of mandated benefits made available to that state's residents. Additionally, a person who is not actually a resident of a state may be more likely to seek care from out-of-state providers who are not in the health plan's contracted network of providers, resulting in higher cost to the health plans that may eventually be passed on in higher rates to the state's residents.

For these reasons, we recommend that the definition of resident include a requirement of actual residency, in addition to or in place of an intent to reside. We acknowledge that there may be instances that a person may not have a fixed address in a state but still qualify as a resident, such as a person arriving in the state to seek employment, but these circumstances can be addressed with specific regulatory language as in proposed 42 CFR 435.405(h)(1)(ii).

We also note that the proposed regulation states that a document that provides evidence of immigration status may not be used alone to determine State residency. See 45 CFR 155.315(c)(4). This is unclear in light of the language in the preamble stating that a document providing evidence of immigration status may not be used alone to determine lack of State residency. There would be no reason to prevent an Exchange from using such a document to positively determine State residency and we recommend clarifying this regulatory language.

Verification process for insurance affordability programs (Section 155.320)

The Health Connector would recommend clarification on when self attestation is acceptable for income. For example, in an instance where IRS and state Department of Revenue quarterly wage data is not consistent with what the applicant states, please provide guidance as to whether the applicant would be required to provide verification.

The Health Connector also requests clarification of the definition of "*reasonably compatible*" used throughout this section, as in § 155.320 (C) (2) (B), If such data sources are unavailable or information in such data sources is not reasonably compatible with the application filer's attestation, the Exchange may request additional documentation to support the attestation within the procedures specified in 45 CFR 435.952.

We also respectfully request additional information on the process that must occur if the unverified income of an applicant meets the Medicaid FPL eligibility requirement

Minimum essential coverage (Section 155.340)

Under the proposed regulations, the Exchange must determine whether an applicant has access to minimum essential coverage that is affordable under federal standards and that provides minimum value. An individual with access to such coverage would not be eligible for premium tax credits.

The eligibility verification process requires that an applicant attest to enrollment in employer-sponsored insurance or eligibility for qualifying coverage. We agree with the proposed regulations that an applicant will be likely to possess sufficient information as to whether he or she is enrolled in an employer-sponsored insurance plan so that an attestation can be accepted. However, an applicant is unlikely to possess sufficient information as to whether a plan offered by an employer constitutes qualifying coverage. We support the creation of a central database containing information from employers about their coverage, which can be used as a source for verifying self-reported information about an applicant's eligibility for qualifying coverage. Given the fact that applicants are required to report the identity of their employers, a database containing the identities of employers that have reported pursuant to IRC § 4980H, as added by Section 1513 of the ACA, that they have failed to offer minimum essential coverage would permit some measure of electronic verification. Additionally, the existence of such a database could permit the inference that an applicant who reported working for a large employer not in the database was eligible for minimum electronic coverage. We would also support any effort to leverage the notices under Section 18B of the Fair Labor Standards Act, as added by Section 1512 of the ACA, as a means of verifying an applicant's attestation of lack of eligibility for qualifying coverage. Unless the Exchange had the ability to obtain electronic verification of the applicant's attestation, it will be difficult to implement the verification

process without requiring documentation in the large majority of cases. In view of that fact, we would suggest that the requirement that the Exchange "must verify" the attestation about eligibility for qualifying coverage be made more flexible, for instance by requiring verification through available electronic sources or by verifying in cases when the attestation is not reasonably compatible with other information, e.g. an applicant reports lack of eligibility while also reporting employment with a large employer.

The proposed regulations state that, when an Exchange determines that an applicant is eligible for premium tax credits because that individual lacks access to qualifying coverage, the Exchange must notify that individual's employer and identify the employee. We recognize that such a determination has potential financial consequences for an employer. However, we are concerned that the identification of an employee might expose the employee to potential retaliation by an employer, or that the prospect of such notification might chill an employee's decision to apply for premium tax credits through the Exchange. We urge HHS to consider modifying this requirement so that the employee's identity not be provided to the employer.

Redeterminations (Section 155.310)

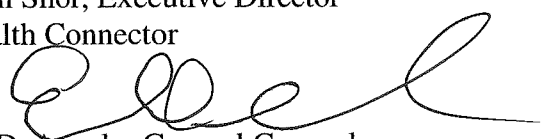
We recognize that the proposed regulations regarding redeterminations of persons already found eligible for Exchange programs have balanced the advantages of making eligibility decisions based on current information against the interest of reducing administrative complexity the Exchange and for enrollees. We support the decision in the proposed regulations to permit a person who has been determined eligible for a Qualified Health Plan (QHP), but who does not immediately enroll in such a plan, to enroll prior to the annual redetermination period without the need for a new redetermination.

We further appreciate efforts made to simplify the redetermination process by permitting the Exchange to proceed with information contained in the redetermination notice if the individual to whom the notice is sent does not return it with a signature within 30 days. This process could be made even simpler if the Exchange were permitted to send the redetermination notice with instructions directing the individual to return the notice only in instances when the individual is disputing information contained in the notice.

We urge that the regulations not require authorization from HHS in order for an Exchange to determine a reasonable point in a month after which a change captured through redetermination will not be effective until the first day of the second month. Administrative and operational requirements may limit a health plan's ability to enroll someone immediately upon determination. Recognizing this, there does not appear to be a compelling need for a uniform cutoff date across all Exchanges. Each Exchange should be able to determine a reasonable cut off point to accommodate the administrative limitations of the carriers in the Exchange, without the added burden of seeking prior authorization from HHS.

Sincerely,

Glen Shor, Executive Director
Health Connector



Ed DeAngelo, General Counsel
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